BEFORE THE ARIZONA MEDICAL BOARD

In the Matter of **JUSTIN WEISS, M.D.** Holder of License No. **9418** For the Practice of Allopathic Medicine In the State of Arizona.	Board Case No. MD-04-0493B **FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER** (Letter of Reprimand)

The Arizona Medical Board ("Board") considered this matter at its public meeting on August 11, 2005. Justin Weiss, M.D., ("Respondent") appeared before the Board with legal counsel Tom Slutes for a formal interview pursuant to the authority vested in the Board by A.R.S. § 32-1451(H). The Board voted to issue the following findings of fact, conclusions of law and order after due consideration of the facts and law applicable to this matter.

FINDINGS OF FACT

1. The Board is the duly constituted authority for the regulation and control of the practice of allopathic medicine in the State of Arizona.

2. Respondent is the holder of License No. 9418 for the practice of allopathic medicine in the State of Arizona.

3. The Board initiated case number MD-04-0493B after receiving notification of a malpractice settlement involving Respondent's interpretation of mammograms and other studies involving a 67 year-old female patient ("FD"). Respondent read FD's mammograms in August 1996 and August 1997 and interpreted them as negative. In August 1998 FD informed her primary care physician ("PCP") she had a lump in her left breast. PCP referred FD to El Rio Health Center, a facility for whom Respondent read radiologic films. FD underwent a routine screening mammogram rather than a diagnostic study. Respondent reported the examination as showing no primary or secondary occult

signs of malignancy. FD underwent additional radiologic studies in November 1998, May 1999 and June 1999. Respondent reported no signs of malignancy in any of these studies. In August 2000 FD underwent a mammogram at another facility and was diagnosed with breast cancer.

4. Respondent testified he had been serving EL Rio for over twenty years doing mammography without incident. Respondent was asked what PCP requested when he referred FD to Respondent. Respondent testified PCP asked for attention to the left breast in the 12:00 to 2:00 position and ordered a mammogram without specification. Respondent was asked if he considered PCP's order to be for a screening or diagnostic mammogram. Respondent testified it was a gray area and was not clearly directed as a diagnostic study, but the way El Rio performs studies is they are done by a technologist primarily as a screening study unless there is clear indication by the clinician that the study is for a patient with a lump, a mass, or the attending physician orders it as a diagnostic study. Respondent noted he is not physically present at El Rio most of the time and when the request is not defined as "diagnostic" or "screening" the technologist makes the decision whether to do a diagnostic or screening mammogram.

5. Respondent testified that in 1998 the films from El Rio were delivered to his private office and since 2001 he makes a once or twice a day trip to El Rio to read studies. Respondent stated he was never on site to either do the evaluation himself or do an examination of FD or any patient. Respondent noted El Rio mainly does screening mammograms for patients that cannot get studies anywhere else and the studies were done in a way that was traditional before the advent of women's diagnostic centers.

6. Respondent testified he believed he looked at FD's related history because that is his general practice, but he has no specific recollection of doing so. Respondent testified he read FD's films as normal in 1998, but also included a disclaimer, which is not

his normal practice. Respondent stated it was his practice to include a disclaimer whenever there is a physical finding either detected by the clinician or the patient or if the patient has a very dense breast. Respondent testified his disclaimer comment at the end of his report of FD is not his normal disclaimer. Respondent testified he does not always suggest a biopsy or suggest further evaluation when there is no hard sign, but he also leaves it open to the clinician that they can do further testing if they feel, based on physical examination or history, that the patient warrants further work-up.

7. Respondent was asked if PCP would have been aware of the meaning of Respondent's disclaimer – would PCP have interpreted the disclaimer as Respondent suggesting PCP look further. Respondent testified that was his expectation, but he did not know specifically whether that was PCP's understanding. Respondent was asked if there was a reason he did not go into more detail and suggest if a mass is present a biopsy might be indicated. Respondent testified he thinks it is pretty clear, at least in clinical medicine, that clinicians know that if a finding is palpable the mammography is not 100% accurate in diagnosing breast cancer. Respondent was asked if he would have suggested a more frequent follow-up for FD than a yearly routine. Respondent testified there is a category of "probably benign" that is the American College of Radiology finding of "normal," but recommended a re-screen every six months. Respondent stated it was a judgment call and it is not black and white as to suggesting 100% of the time the patient have a follow-up in six months.

8. Respondent was asked why, if the August 1998 film did not recommend more frequent mammograms, FD had a subsequent film in November. Respondent testified he presumed the clinician had, based on the history presented to Respondent at the time, a presentation with a "breast lump, 2:00 to 3:00 o'clock, three to four centimeters from the areola." The Board noted the November evaluation included spot

compression and mammography and Respondent reported nothing was seen. Respondent was asked if his comment that "further evaluation, however, should not be dissuaded" was another disclaimer. Respondent testified that because the physical finding was present it should supersede any diagnostic imaging. Respondent was asked if he would describe the mammogram, ultrasound and spot compressions as diagnostic. Respondent indicated they were in the area of diagnostic studies.

9. The Board noted FD returned to El Rio in May 1999 and Respondent's diagnosis on the mammogram is "questionable, slight distortion of the left breast." The Board noted FD had been seen three times in less than one year and asked Respondent what he saw in the May 1999 films. Respondent testified he thought he had seen some distortion he believes in the superior hemisphere of the left breast and he recommended spot compression views that were done in June 1999. Respondent was asked what his reading was of the June 1999 films. Respondent testified he had interpreted the area as compressing, and therefore, based on the criteria of being compressed, and not seeing the distortion, that it was most likely benign. The Board noted the medical consultant who reviewed the case opined the films were inadequate and asked Respondent what he would have done next if he felt the films were inadequate. Respondent testified the technologist performed the spot compression views on the plane and explained to him that she could not locate the area on the second plane. Respondent note ideally you should routinely expect to see spot compression views in two planes.

10. Respondent was asked whether, if he felt the technologist had been inadequate in her preparation of FD, he would have ordered or asked FD to return to see if he could get better views. Respondent testified in retrospect he would have had FD return and that is his policy now – he will not accept a unilateral spot compression view with only one plane. The Board asked Respondent about the December 1999 films that

were based on his six month recommendation for follow-up. The Board noted in FD's history with PCP she continued to express concern over a breast mass that she has felt for over one year. Respondent was asked what he saw on the December 1999 films in December 1999. Respondent testified in December 1999 he had no history from the clinician and FD's chart was not provided to him. Respondent has a form that asks for related history and it was left blank. Respondent testified he commented in his report that there was a stable appearance of the left breast findings with what he thought at the time was asymmetric fibroglandular tissue.

11. Respondent was asked whether, since the December 1999 visit was the six-month follow-up visit, he had the old film and whether he compared them. Respondent testified he compared the actual radiographs at that time and saw findings that he interpreted as asymmetric fibroglandular tissue. The Board noted FD was one and one-half years from the first examinations and Respondent has been noting a left breast abnormality and continuing to report he sees nothing that concerns him on the mammograms. Respondent noted he commented that there was asymmetry and questionable distortion, so obviously it was a concern to him, but he did not believe the findings based on mammography were suspicious for malignancy.

12. Respondent was asked if he ever contacted PCP in regard to concerns or findings or ever communicated to PCP that he was not seeing anything; so what was going on from PCP's end that he continued to send FD for studies. Respondent testified he did not recall. The Board noted PCP kept noting she was concerned about this mass and finally, when the films are done elsewhere in August 2000 the diagnosis of breast cancer was made. The Board noted the August 2000 films noted a 2 to 3 centimeter mass, speculated, skin retraction and left adnexal adenopathy. Respondent was asked if, in a patient such as FD who has been evaluated for years, the findings would indicate

a fairly advanced case of malignancy. Respondent testified it would either be an advanced or aggressive malignancy.

13. Respondent was asked if, when there is a suspicion of a mass and he orders an ultrasound, it is left up to the technician to decide when and where and how to do the ultrasound compression or does the physician palpate the mass and tell the technologist to try to look in a particular place. Respondent testified that in breast centers where there is a full-time radiologist on site it is routine for the radiologist to be present and confirm the findings that are being scanned. Respondent noted that at El Rio it was up to the technician to decide how and where to look at the area in question.

14. Respondent was asked if he was aware that PCP was questioning something in the left breast, a skin retraction. Respondent testified the mammogram order forms he was given did not say "skin retraction," but said "attention, 12-2 o'clock position." Respondent noted there is a history of a breast lump, and then the spot compression views and sonogram were performed. Respondent was asked if his comment about there being "questionable distortion" is a red flag. Respondent testified it was, but noted if you do spot compression views and they are of good quality and the area does compress, it is most likely benign. Respondent noted this is not 100% accurate and that is why the clinical findings of anything that might be palpable should supersede the mammogram.

15. The Board reviewed the films taken of FD. Respondent was asked if he made the ink mark on the December 1999 film. Respondent did not recall marking the lymph nodes, but noted he had been trained that lymph nodes in and of themselves are not a reliable indicator of any significant breast disease, only in the context of seeing a mass or some other suspicious abnormality are lymph nodes an indicator and should be commented upon. Respondent was asked in FD's situation where she is being followed

and she and PCP have concerns and are getting more frequent evaluations, would the lymph nodes be something he would look to for more information on what is going on. Respondent testified that, in retrospect, with the lymph nodes and the history provided he certainly would be more attuned to that. Respondent noted if he commented on all positive lymph nodes in terms of being greater than two centimeters or one centimeter and a half, in asymptomatic patients, the false positive rate would skyrocket and defeat the whole purpose of mammograms.

16. Respondent testified he has changed his protocol and will not allow El Rio to perform diagnostic mammograms without his presence. Respondent also noted he has informed El Rio he will not perform mammography after September 1, 2005. Respondent testified he just completed a continuing education course at the University of California, San Francisco and during the course there was a very significant presentation on the medical-legal aspects of breast imaging. Respondent noted he has advocated that El Rio contract with a dedicated women's imaging specialist to do mammography.

17. Respondent was asked if FD's history of having a palpable breast mass along with the finding of adenopathy would trigger a biopsy or more intense workup than just repeating the mammogram in six months. Respondent testified it would from a clinical standpoint, but from a radiologist's standpoint it would not warrant a radiologist recommending a biopsy. Respondent was asked if, in hindsight, he could have done things differently at the time FD was being seen at El Rio. Respondent testified he certainly would have been more aggressive and would have communicated more aggressively with PCP.

18. Respondent was asked for clarification of how the decision is made to do screening versus diagnostic mammography, who makes the decision, and who is responsible for the decision. Respondent testified generally the primary ordering

physician or physician assistant or nurse practitioner determines which study is done. Respondent stated if the finding is abnormal/suspicious, the study can be converted to a diagnostic mammogram – it may mean additional views, magnification views or spot compression views. This is usually determined by the radiologist, although a well-trained mammography technologist can do additional views without the radiologist present.

19. Respondent testified that two board-certified radiologists reviewed his studies and concurred with Respondent in their report of August 2000 that the mass found in FD in 2000 was a new mass.

20. The standard of care required Respondent, as a radiologist, to conduct more detailed evaluations of FD because there was a mass noted in her breast and to properly interpret the radiologic studies.

21. Respondent deviated from the standard of care because he did not conduct more detailed evaluations of FD and failed to properly interpret the radiologic studies.

22. FD was harmed because Respondent failed to properly interpret radiologic studies and her diagnosis of breast cancer was delayed. The delay in diagnosis also reduced FD's chances for a better outcome.

CONCLUSIONS OF LAW

1. The Arizona Medical Board possesses jurisdiction over the subject matter hereof and over Respondent.

2. The Board has received substantial evidence supporting the Findings of Fact described above and said findings constitute unprofessional conduct or other grounds for the Board to take disciplinary action.

3. The conduct and circumstances described above constitutes unprofessional conduct pursuant to A.R.S. § 32-1401(27)(q) ("[a]ny conduct or practice that is or might be harmful or dangerous to the health of the patient or the public.")

ORDER

Based upon the foregoing Findings of Fact and Conclusions of Law,

IT IS HEREBY ORDERED that Respondent is issued a Letter of Reprimand for failing to order further diagnostic studies and failure to diagnose a malignant breast mass.

RIGHT TO PETITION FOR REHEARING OR REVIEW

Respondent is hereby notified that he has the right to petition for a rehearing or review. The petition for rehearing or review must be filed with the Board's Executive Director within thirty (30) days after service of this Order. A.R.S. § 41-1092.09(B). The petition for rehearing or review must set forth legally sufficient reasons for granting a rehearing or review. A.A.C. R4-16-102. Service of this order is effective five (5) days after date of mailing. A.R.S. § 41-1092.09(C). If a petition for rehearing or review is not filed, the Board's Order becomes effective thirty-five (35) days after it is mailed to Respondent.

Respondent is further notified that the filing of a motion for rehearing or review is required to preserve any rights of appeal to the Superior Court.

DATED this 13th day of October, 2005.

ARIZONA MEDICAL BOARD 1913 STATE OF ARIZONA

THE ARIZONA MEDICAL BOARD

By _____
TIMOTHY C. MILLER, J.D.
Executive Director

ORIGINAL of the foregoing filed this 13th day of October, 2005 with:

Arizona Medical Board
9545 East Doubletree Ranch Road
Scottsdale, Arizona 85258

Executed copy of the foregoing
mailed by U.S. Certified Mail this
13th day of October, 2005, to:

Tom Slutes
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Executed copy of the foregoing
mailed by U.S. Mail this
13th day of October, 2005, to:

Justin Weiss, M.D.
Address of Record

Lisa McGraw